MRSIS IMPLEMENTATION:
REGIONAL PROVIDER MEETINGS
JUNE 14 and 26-28, 2006

June 14, 2007
Region IV: Autauga Western Elmore Arc (Smith Center), Dale County MRB, The Learning Tree, Autauga Elmore MRB, SpectraCare (Wiregrass MHB), Magnolia Wood, MCCRR, South Central AL MHB, VOA (Montgomery), Hope Project, East AL MHC, East Central MH/MR, MASPMR, MARC (Montgomery Arc), Dothan-Houston County MRB (Vaughn-Bloomberg), Cahaba Center, HRDI, Milton Road (H.E.L.P), Nolrav

Concerns:

- Fear of the unknown
- Flexibility
- Cost
- Transitioning case management agencies into the new workflow

Questions:

- What safeguards are there on persons we pay both state and local match on so that our match money doesn't follow the person?
- What about Early Intervention billing? Will E.I. come under MRSIS in the future?

Response:

- There is no sure way to ensure that all state money stays with the provider. If a person that is funded with local money wants to move then we can swap that person's local match with a state matched person so that it is state money that follows the person; however there is no guarantee that state money will stay with the provider. That situation occurs right now—it just takes contract amendments to do it which slows the process down, but it does already happen.
- Early Intervention is a separate system and will not be billed through the MRSIS system.

June 26, 2006
Region III: L'Arche, Mobile Mental Health, Nobles Group Home, Scott Residential, Williams Group Homes, Parker Adult Foster Homes, A&E, Hill Group Homes, SW AL MHC, The Learning Tree, MRDD Board Inc., Mobile Arc, House of Philadelphia, Petway Residential, ECI

Concerns:

- Duplicate entry for a provider that has an information system similar to SPES
- Span billing
- How to prepare for the upcoming change in billing

Questions:

- Once a bill has been submitted to MRSIS, but has not been sent to EDS for adjudication, can an end user go into MRSIS to make a revision or will the user have to wait until the next check write to reverse the claim and send a corrected claim?

- Will the provider identification number remain the same?
- Will E.I. go through the MRSIS system?
- How does a new person get a user license?
- How does the billing agent's license work?
- How are the user licenses issued?
- How will the user license work for providers that serve both SA and MR clients?
- Can an old claim be copied and updated for the next months billing in MRSIS?
- How will ineligible funding be handled?

Response:

- It appears likely that MRSIS would allow an end user to go into a claim that has been adjudicated by MRSIS but not sent to EDS, and make revisions.
- At this time there is no plan to change provider identification numbers.
- E.I. will not be billed through the MRSIS system.
- There will be a standard procedure for applications, and for issuing and terminating a user license. This procedure is still under discussion.
- Billing agents may be issued a MRSIS user license for billing and retrieving reports.
- User licenses will be issued based on the number of staff needed to complete specific tasks in MRSIS. In addition, the number of licenses issued to each provider will depend on the contracted number of licenses that DMR has with Harmony. If a provider wishes, they may be able to purchase additional user licenses, but the process for payment has yet to be worked out.
- Providers that bill both Substance Abuse and Mental Retardation services will have one license that will accommodate both Divisions.
- It appears unlikely that a claim can be copied from a previous month and dates changed for the next months billing, in Two Part Harmony. It should be noted, however, that, unlike with PES, much of the necessary information needed to complete the claim will already be filled in with Two Part Harmony when one begins the billing process.
- "Ineligible" funding is "State Only" funding in MRSIS and will be handled as a separate funding code. The services will need to be prior authorized and manually priced. The payment may be sent to providers during the week that Medicaid does not send payment. If these clients don't have a case manager the direct service provider will need to communicate directly with the regional office so that the individuals can be set up in MRSIS and be given a prior authorization.

June 27, 2006
Region V: PHP of AL, Glenwood, Jefferson County MHC, UCP of Birmingham, St. Andrews Place, Arc of Jefferson County, JBS, Randolph County Learning Center, Calhoun Cleburne MHC, St. Clair County MRDD, Blount County MRDD, Chilton Shelby MHC, East Central AL UCP, Bridget's Home, Arc of St. Clair, Rainbow Omega, Cheaha MHC, Maximum

Concerns:

- Time it takes to get through two systems and meeting the check write dates

- How IRBI rates will work in internal systems
- Span billing
- Transitioning into the new system and the fear of another ECHO
- Local match: making sure it is in the account and having to identify client by client local match versus state match.
- Exceeding the number of units on the Plan of Care (justifying for Medicaid and getting paid for the additional units)
- Prior Authorization system and how it works when changes need to be made
- Validating legitimate claims from sub-contractors and getting billing information from sub-contractors
- Medicaid compliance and compliance with the POC (will the case manager know which provider billed for what services)

Questions:

- How will the PA work when a client changes provider? Will there need to be a new PA number?
- How will claims for October through December services work?
- Will the system be able to handle two case managers billing for one client? For example, currently if two case managers share a client units can not be combined so one of the claims is rejected and a corrected claim will have to be sent.
- Will there be an 837 companion guide for 837 submitters?
- How will state only funded consumers be processed and paid?
- Can the direct service provider expect to have the Plan of Care in hand for billing from the case manager?
- Can the direct provider view the Plan of Care?
- What happens if a provider exceeds the number of units that are on the POC (i.e. Personal Care) can we bill or will the POC need to be changed?
- Will the case manager know what the provider billed and what they provided in order to justify the units?
- When does local match funds need to be in the community account?
- Is the user license for the person or the agency?
- Will sub-contractors have a user license?
- Will ICF/MR bill MRSIS or Medicaid if they are receiving local match funding?
- Do administrators need a user license?
- Can we download data without having Crystal reporting software?
- How will the scanned POC be saved?
- Is there a minimum requirement for high speed internet?
- Would a provider that serves both MR and SA require 2 different licenses?

Response:

- The prior authorization system will require that a new prior authorization number be issued is a client is changing providers. For Two-Part Harmony users the prior authorization number will be linked to the person. For 837 submitters the prior authorization number is something that is required for billing and will be up to the provider to maintain.

- October through December services will not have a prior authorization number and MRSIS will run these claims through without editing for the authorization.
- Currently we are working with Harmony to create a case management billing system similar to SPES. This system allows the case manager to input progress notes and have the system calculate units of case management to be billed. We have heard that EDS will allow two case managers to bill for the same consumer and that EDS will not allow two case managers to bill for the same consumer. We will try to find out which of these is correct. We do not intend to design an edit that would prohibit two case managers from billing for the same consumer.
- There will be training and a user manual for both Two-Part Harmony users as well as 837 submitters.
- State Only funded services in MRSIS will be handled as separate procedure codes. The services will have to be prior authorized and manually priced. The payment may be sent to providers during the week that Medicaid does not send payment.
- Currently the case manager is the only person that can view the full Plan of Care, however there may be a report available in Two-Part Harmony that would allow the provider to view (not modify) the Plan of Care. This is something we will need to present to the Harmony Project Manager. The provider will be able to view all prior authorizations for their agency through Two-Part Harmony.
- The Plan of Care will authorize units for one year. There will be some flexibility to use more units in one month than another, however if you should go over the POC units it is important to be sure to document and justify the reason for Medicaid.
- MRSIS will be able to generate a report for all units billed by a provider. This may help case managers justify units when necessary.
- Local match must be in the community account before the claim for services that rely on local match funding are submitted to MRSIS. If the local match is not in the account the system will search for the funds for 30 days. If after 30 days the local match funds are not available to pay the match for the claim the claim will be denied.
- User license will be given to an agency for an identified user that has completed MRSIS training. If an individual leaves the agency the license will need to be terminated and once the position is filled a new user license will be assigned. In addition, the license is for individuals that will be working in the system regularly either entering claims, viewing reports, or case management entry into the system.
- Sub-contracting agencies will not have a user license.
- An ICF/MR that has local match funding will bill Medicaid.
- An administrator may not need to have a license as there are many reports that will be accessible for downloading into Excel or Word and/or printing.
- Harmony designs all of the reports accessible through Two-Part Harmony and MRSIS with Microsoft Crystal Reports. In order to view reports on-line you will not need to have Crystal Report software. Crystal Report will allow a user

to export the report into a Word or Excel document. In addition, forms will be printable so that hard copies can be maintained.

- Some documentation, mainly anything that requires an original signature, will have to be scanned into MRSIS. The scanning may be done at the agency or sent into the regional office. Once the document is scanned into MRSIS it is attached to the consumer record. The original may be kept in that consumer's file as a back up.
- There is not a minimum requirement for high speed internet in order to access MRSIS. As long as there is a high speed connection (DSL, satellite, etc.) an agency should have the ability to access and utilize the MRSIS web site. However, the higher the speed, the faster MRSIS will work.
- A provider serving and billing for both Substance Abuse and Mental Retardation services will only require one license. The one license will have both SA and MR functionality for billing and retrieving reports.

June 27, 2006
Region II: Ability Alliance of West AL, Indian Rivers MHC, West AL MHC, Northwest AL MHC, VOA, Arc of Walker County, Tri County MRDD, The Arc, RHOC, UCP of West AL, Future Living Community Services

Concerns:

- Justifying units that are billed (exceptions to the POC)
- Local match (what happens if a state funded person leaves, do I loose money; identifying local match, can I change my mind about who receives local match funding)
- Workflow (right information getting to the right person)
- Getting comfortable with using a computer
- Case Managers being responsible for funding source
- On-going training
- User license and the amount of time it takes to terminate and re-issue

Questions:

- Will local match be going into a trust fund that anyone can use?
- Can all state funding be used first before using local match?
- Will the supervisor have the ability to review paperwork before it goes to RCS?
- What is Crystal Reports?
- Can a sub-contractor buy a user license?
- Will the sub-contractor need to go through the contracting agency to get reports?
- Has there been any consideration to link the on-line case management training with MRSIS?

Response:

- Local match will be going into community accounts set up for individual providers that receive donations. The local match will not go into a pool that everyone can use.
- Yes, state funding can be used before local match, in the case of a "hybrid" authorization. This will actually be two authorizations for the same service, and

the date spans will have to be different. The authorization with the earlier date span can be the one with the state funding. We suggest, however, that this type of set up is cumbersome to set up and slightly more difficult to bill.

- We have requested that an additional security level be established in MRSIS that would allow for the case manager supervisor to review all paper work before submitting it to the regional office.
- Harmony designs all of the reports accessible through Two-Part Harmony and MRSIS with Microsoft Crystal Reports. In order to view reports on-line you will not need to have Crystal Report software. Crystal Report will allow a user to export the report into a Word or Excel document. In addition, forms will be printable so that hard copies can be maintained.
- At this time it is not known whether a sub-contractor can buy a user license or not.
- Sub-contractors will not receive a user license, so in order to receive reports they must go through their contracting agency. One way a sub-contractor can get billing information to a provider is through the use of an 837.
- The on-line training system is not intended to be linked to MRSIS.

June 27, 2006
Region I: Regional 310 Authority, Greater Etowah 310, Madison MRB, Dekalb MRB, Marshall Jackson 310, NCAMRA, Cullman County 310, Northeast AL MR/DD, SCOPE, Marshall County Arc, Arc of Shoals, Arc of Jackson County

Concerns:

- Case managers entering date on time
- Case managers being responsible for knowing the funding source and the procedure code
- Staff comfort level with computers
- Claims matching to the payment
- Supervisory oversight for clinical and financial documents before they are sent to RCS
- 24 hour turn around time for the "CSR" report
- Not receiving provider data in time to do billing
- Prior authorization system and how it will work
- Computer requirements
- User license turn around time
- Correcting wrong information in a claim
- Cash flow

Questions:

- Will there be an opportunity to have a hard copy of information to place in consumer files?
- If a person looses eligibility will they need to recreate all the waiver paperwork again? How will loosing eligibility effect the workflow and the progress notes that are required to continue to be documented?

- How will DHR match work in the new system? Will DHR and DHR kids be identified in MRSIS and in the local match account?
- Can case manager supervisors get a report of all the outstanding ticklers or outstanding tasks for all the case managers they supervise?
- Will providers be able to view consumer reports such as eligibility?
- How long will it take for information to process in the MRSIS system? For example, once information has been entered into the system how long of a delay to get the information to billing?
- Can multiple case managers access and bill for the same client?
- Will there be a way to view generalized reports such as outcome data, consumer satisfaction, comparing regional information, etc.?
- Does the prior authorization number stay the same if a person stops services and changes providers?
- How much data input will contractors have to do?
- How will changes to the Plan of Care affect a person's coverage? Changes happen very frequently to the Plan of Care.
- Will the provider's QMRP have a user license because they do most of the paper work to include the quarterly narrative?
- How will the LTC2 process work?
- How will the Prior Authorization System work: will there need to be more than one Prior Authorization number per consumer per year?

Response:

- Hard copy may be printed for putting in a file.
- MRSIS will check for Medicaid eligibility at least once a month. Once documentation has been created in MRSIS it will always be accessible. The loss of eligibility will not affect the waiver enrollment paperwork that has been previously submitted. There may need to be modifications, but there is no electronic connection built into MRSIS that would not allow a user to access a consumer file if eligibility has been lost.
- DHR match will have a unique funding code and that money will be identified in the agency community account. Claims billed with the DHR funding code will be processed like other local match in that if the funds are not available the system will continue to search for the match for 30 days. If after 30 days the match is still not available the claim will fail.
- Case manager supervisors will have the ability to view all outstanding tasks assigned to their case managers. This will be available on the "tickler" list.
- Some reports will be viewable to the direct provider through Two-Part Harmony. We believe this will include an eligibility report, and we know the direct provider can view, but not change, the plan of care.
- Once information is entered into MRSIS, unless there is a supervisory hold, data will be submitted immediately.
- Currently, there is nothing in MRSIS to prevent two case managers from billing for services provided to the same person.
- As we move forward with MRSIS and data collection there will be several ways for providers to view generalized reports. Aggregate reports could be posted on

the web-site through Data Mart for everyone to view. Also, individualized reports can be hard coded in Two-Part Harmony for individual providers to view.

- The prior authorization number will change if a person leaves services and enters services somewhere else.
- The MRSIS system has been pre-loaded with all current waiver clients and we will be creating prior authorizations for all of these people. Case mangers will need to complete basic demographic information at the time of re-determination. Direct providers will not be asked to input data at this time.
- Changes to the Plan of Care should not affect the person's coverage. If the change requires additional money then the regional fiscal manager will need to ensure the money is available before prior authorizing the change.
- The state will not be providing provider QMRPs with a user license. We are researching various reports that may come out of Two-Part Harmony for the benefit of the provider and the QMRP.
- The LTC2 will continue to work basically the same. We want to synchronize the LTC2 dates with the POC dates and we are building in a reminder to the case manager that eligibility re-determination is near. We will consider creating a notification process to providers in Two-Part Harmony to inform them of the waiver start dates.
- The Prior Authorization System will work on a fiscal year basis. The Plan of Care will be synchronized with the LTC dates. So any changes to the Plan of Care, if approved, will have to be manually added to the Prior Authorization by the RCS office. The two processes will work separately (POC and PA). The good news, though, is that in most cases one prior authorization number per year will be all that is required.